FOR OHF USE

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038729

Facility Name: Beacon Street Place

Address: 4838 Beacon Drive (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: (217) 422-1761 **Fax #** ( )

IDPA ID Number: 37-1273581

Date of Initial License for Current Owners: 5/24/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Mark S. Wood, CPA Telephone Number: (217) 875-2655

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) David M. Jacobus

(Title) Owner

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Mark S. Wood, CPA

(Firm Name & Address) May, Cocagne & King, P.C.
1353 E. Mound Road, Suite 300, Decatur, IL 62526

(Telephone) (217) 875-2655 Fax # (217) 875-1660

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

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I. IDPH Facility ID Number: 0036764

Facility Name: Autumn Leaves, Inc. d/b/a Hickory Street Place

Address: 3905 East Hickory (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: (217) 422-8231 **Fax #** ( )

IDPA ID Number: 37-1273581

Date of Initial License for Current Owners: 5/24/93

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT	[X] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code	[ ] Corporation	[ ] Other
	[X] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] Other	

In the event there are further questions about this report, please contact
Name: Mark S. Wood, CPA **Telephone Number:** (217) 875-2655

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Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) David M. Jacobus

(Title) Owner

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Mark S. Wood, CPA

(Firm Name & Address) May, Cocagne & King, P.C.
1353 E. Mound Road, Suite 300, Decatur, IL 62526

(Telephone) (217) 875-2655 Fax # (217) 875-1660

MAIL TO: OFFICE OF HEALTH FINANCE
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I. IDPH Facility ID Number: 0038737

Facility Name: Autumn Leaves, Inc. d/b/a Fourty-fourth Street Place

Address: 1479 South 44th Street (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: (217) 422-2773 **Fax #** ( )

IDPA ID Number: 37-1273581

Date of Initial License for Current Owners: 5/24/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Mark S. Wood, CPA Telephone Number: (217) 875-2655

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) David M. Jacobus
(Title) Owner

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Mark S. Wood, CPA
(Firm Name & Address) May, Cocagne & King, P.C.
1353 E. Mound Road, Suite 300, Decatur, IL 62526
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 5/24/93

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,794			5,794	13
14	TOTALS	5,794			5,794	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.21%

D. How many bed-hold days during this year were paid by Public Aid?
46 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 5/24/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/24/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basi

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	53,938	2,640	3,230	59,808		59,808		59,808			1
2	Food Purchase		56,540		56,540	(5,937)	50,603		50,603			2
3	Housekeeping	52,645	3,337		55,982		55,982		55,982			3
4	Laundry			1,707	1,707		1,707		1,707			4
5	Heat and Other Utilities			15,484	15,484		15,484	2,235	17,719			5
6	Maintenance	13,432	1,640	17,524	32,596		32,596	1,295	33,891			6
7	Other (specify):*			4,973	4,973		4,973		4,973			7
8	**TOTAL General Services**	120,015	64,157	42,918	227,090	(5,937)	221,153	3,530	224,683			8
	B. Health Care and Programs											
9	Medical Director			8,185	8,185		8,185		8,185			9
10	Nursing and Medical Records	172,954	4,102	10,153	187,209		187,209	791	188,000			10
10a	Therapy											10a
11	Activities	55,143	8,454		63,597		63,597		63,597			11
12	Social Services	52,835		1,120	53,955		53,955		53,955			12
13	Nurse Aide Training	5,508			5,508		5,508		5,508			13
14	Program Transportation			5,238	5,238		5,238		5,238			14
15	Other (specify):*			133,213	133,213		133,213	(132,196)	1,017			15
16	**TOTAL Health Care and Programs**	286,440	12,556	157,909	456,905		456,905	(131,405)	325,500			16
	C. General Administration											
17	Administrative	24,271	3,295		27,566		27,566		27,566			17
18	Directors Fees											18
19	Professional Services			13,575	13,575		13,575	841	14,416			19
20	Dues, Fees, Subscriptions & Promotion			2,243	2,243		2,243		2,243			20
21	Clerical & General Office Expenses	10,892		31,628	42,520		42,520	(17,763)	24,757			21
22	Employee Benefits & Payroll Taxes			42,487	42,487	5,937	48,424		48,424			22
23	Inservice Training & Education											23
24	Travel and Seminar			519	519		519	12	531			24
25	Other Admin. Staff Transportation			3,072	3,072		3,072		3,072			25
26	Insurance-Prop.Liab.Malpractice			19,800	19,800		19,800	138	19,938			26
27	Other (specify):*											27
28	**TOTAL General Administration**	35,163	3,295	113,324	151,782	5,937	157,719	(16,772)	140,947			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	441,618	80,008	314,151	835,777		835,777	(144,647)	691,130			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Autumn Leaves, Inc. #0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			10,351	10,351		10,351	30,080	40,431			30
31	Amortization of Pre-Op. & Org											31
32	Interest			14,084	14,084		14,084	13,710	27,794			32
33	Real Estate Taxes			8,057	8,057		8,057		8,057			33
34	Rent-Facility & Grounds			74,670	74,670		74,670	(74,670)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			107,162	107,162		107,162	(30,880)	76,282			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,506	53,506		53,506		53,506			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			53,506	53,506		53,506		53,506			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	441,618	80,008	474,819	996,445		996,445	(175,527)	820,918			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program	(132,196)	15		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,215	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (118,981)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(56,546)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (56,546)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (175,527)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39	Therapy		X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Programs		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Autumn Leaves, Inc. d/b/a Hickory Street Place

ID# 0036764

Report Period Beginning: 1/1/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Hickory Street Place # 0036764 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,235	0	0	0	0	0	0	0	0	0	2,235	5
6	Maintenance	0	1,295	0	0	0	0	0	0	0	0	0	1,295	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	3,530	0	0	0	0	0	0	0	0	0	3,530	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	791	0	0	0	0	0	0	0	0	0	791	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(132,196)	0	0	0	0	0	0	0	0	0	0	(132,196)	15
16	**TOTAL Health Care and Programs**	(132,196)	791	0	0	0	0	0	0	0	0	0	(131,405)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	841	0	0	0	0	0	0	0	0	0	841	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	(17,763)	0	0	0	0	0	0	0	0	0	(17,763)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12	0	0	0	0	0	0	0	0	0	12	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	138	0	0	0	0	0	0	0	0	0	138	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(16,772)	0	0	0	0	0	0	0	0	0	(16,772)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(132,196)	(12,451)	0	0	0	0	0	0	0	0	0	(144,647)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Hickory Street Place # 0036764 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13,215	3,962	12,903	0	0	0	0	0	0	0	0	30,080	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	46	13,664	0	0	0	0	0	0	0	0	13,710	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(74,670)	0	0	0	0	0	0	0	0	(74,670)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	13,215	4,008	(48,103)	0	0	0	0	0	0	0	0	(30,880)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(118,981)	(8,443)	(48,103)	0	0	0	0	0	0	0	0	(175,527)	45

Facility Name & ID Number Autumn Leaves, Inc. # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
David M. Jacobus	100	Drew Corp d/b/a Moultrie County Comm Center	Lovington, IL	David Jacobus Central Office	Decatur	Central Office for homes

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organizatior	6 Percent of Ownership	7 Operating Cost of Related Organizatior	8 Difference: Adjustments for Related Organizatior Costs (7 minus 4)	
1	V	21	General Office	$ 21,000	David Jacobus, Central Office	100.00%	$ 3,237	$ (17,763)	1
2	V	3	Housekeeping				0		2
3	V	5	Utilities				2,235	2,235	3
4	V	6	Maintenance				1,295	1,295	4
5	V	7	Other				0		5
6	V	10	Medical Supplies				791	791	6
7	V	19	Professional Fees				841	841	7
8	V	20	Licenses/Dues				0		8
9	V	24	Seminars				12	12	9
10	V	26	Insurance				138	138	10
11	V	30	Depreciation				3,962	3,962	11
12	V	32	Interest				46	46	12
13	V	33	Real Estate Taxes						13
14	Total			$ 21,000			$ 12,557	$ * (8,443)	14

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Building Rent - Hickory Street	$ 28,835	David Jacobus	100.00%	$	$ (28,835)	15
16	V	30	Depreciation - Hickory Street		David Jacobus	100.00%	5,081	5,081	16
17	V	32	Interest - Hickory Street		David Jacobus	100.00%	5,288	5,288	17
18	V								18
19	V	34	Building Rent - Beacon Street	22,800	David Jacobus	100.00%		(22,800)	19
20	V	30	Depreciation - Beacon Street		David Jacobus	100.00%	2,745	2,745	20
21	V	32	Interest - Beacon Street		David Jacobus	100.00%			21
22	V								22
23	V	34	Building Rent - 44th Street	23,035	David Jacobus	100.00%		(23,035)	23
24	V	30	Depreciation - 44th Street		David Jacobus	100.00%	5,077	5,077	24
25	V	32	Interest - 44th Street		David Jacobus	100.00%	8,376	8,376	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,670			$ 26,567	$ * (48,103)	39

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	David M. Jacobus	Owner	Various	100.00	29,128	2.5	5.00	Dietary	$ 6,760	1-1	1
2						5	10.00	General Ofc	10,920	21-1	2
3						2.5	5.00	Maintenance	13,520	6-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 31,200		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Autumn Leaves, Inc. # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: David Jacobus, Central Office
Street Address: 2576 Greenway
City / State / Zip Code: Cerro Gordo, IL 61818
Phone Number: (217) 763-2191
Fax Number: (217) 763-2101

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	General Office	Occupied Bed Days	11,066	2	$ 6,182	$ 0	5,794	$ 3,237	1
2	3	Housekeeping	Occupied Bed Days	11,066	2		0	5,794	0	2
3	5	Utilities	Occupied Bed Days	11,066	2	4,268	0	5,794	2,235	3
4	6	Maintenance	Occupied Bed Days	11,066	2	2,474	0	5,794	1,295	4
5	7	Other	Occupied Bed Days	11,066	2		0	5,794	0	5
6	10	Medical Supplies	Occupied Bed Days	11,066	2	1,511	0	5,794	791	6
7	19	Professional Fees	Occupied Bed Days	11,066	2	1,606	0	5,794	841	7
8	20	Licenses/Dues	Occupied Bed Days	11,066	2		0	5,794	0	8
9	23	Training	Occupied Bed Days	11,066	2	0	0	5,794	0	9
10	24	Seminars	Occupied Bed Days	11,066	2	23	0	5,794	12	10
11	26	Insurance	Occupied Bed Days	11,066	2	264	0	5,794	138	11
12	30	Depreciation	Occupied Bed Days	11,066	2	7,567	0	5,794	3,962	12
13	32	Interest	Occupied Bed Days	11,066	2	87	0	5,794	46	13
14	33	Real Estate Taxes	Occupied Bed Days	11,066	2	0	0	5,794	0	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 23,982	$		$ 12,557	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	National City Bank		X	Building/Land-Hickory St.	$2,195.44	5/11/98	$ 180,000	$ Refinanced	5/11/08	8.0000	$ 5,288	1
2	Central Office Allocation	X		Chrysler Financial - Auto	$1,100.00	2/28/01	25,956	Paid Off	3/1/04	0.9000	46	2
3	Soy Capital Bank		X	1999 Grand Jeep	$1,041.07	3/19/02	23,373	13,529	3/18/04	6.4900	956	3
4	National City Bank		X	Building/44th & Hickory St.	$5,011.66	6/19/02	300,348	232,306	6/19/05	6.7500	8,376	4
5												5
	Working Capital											
6	National City Bank		X	Operating Cash	N/A	6/30/02	300,000	248,000	6/30/03	4.2500	13,128	6
7												7
8												8
9	TOTAL Facility Related				$9,348.17		$ 829,677	$ 493,835			$ 27,794	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 829,677	$ 493,835			$ 27,794	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Autumn Leaves, Inc. # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

1. Real Estate Tax accrual used on 2001 report.	$	6,771	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	7,208	2
3. Under or (over) accrual (line 2 minus line 1).	$	437	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	7,620	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru	$	8,057	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year:		
1997	6,558	8
1998	6,718	9
1999	6,508	10
2000	6,989	11
2001	7,208	12

2002 Accrual based on 2001 taxes

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Autumn Leaves, Inc. COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0036764

CONTACT PERSON REGARDING THIS REPORT David Jacobus

TELEPHONE 217-763-2191 FAX #: 217-763-2101

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-13-08-152-009	Hickory Street Place Facility	$ 2,789.02	$ 2,789.02
2.	09-13-20-327-006	44th Street Place Facility	$ 2,393.80	$ 2,393.80
3.	09-13-20-282-008	Beacon Street Place Facility	$ 2,025.48	$ 2,025.48
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 7,208.30	$ 7,208.30

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Hickory Street Plac # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,400 B. General Construction Type: Exterior Vinyl Frame Wood w/sprinklers Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortize([ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility	2,400	1998	$ 27,000	1
2					2
3	TOTALS	2,400		$ 27,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Beacon Street Place # 38729 Report Period Beginning: 1/1/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 1,320 B. General Construction Type: Exterior Wood Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility	1,320	1993	$ 5,000	1
2					2
3	TOTALS	1,320		$ 5,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Forty-fourth Street Plac # 38737 Report Period Beginning: 1/1/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,176 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortize([ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility	2,176	1998	$ 27,000	1
2					2
3	TOTALS	2,176		$ 27,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Hickory Street Plac # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	6		1998	1991	$ 198,175	$ 5,081	25	$ 7,927	$ 2,846	$ 37,653	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1991	550	32	10		(32)	549	9
10	Landscaping			1992	3,496	206	15	233	27	2,388	10
11	Flooring			1994	2,931		6			2,931	11
12	Carpet			1994	1,890		6			1,890	12
13	Carpet			1994	1,179		6			1,179	13
14	Landscaping			1995	519	31	15	35	4	252	14
15	Blinds & Curtains			1996	1,795	149	5		(149)	1,795	15
16	Landscaping			1996	2,418	143	10	242	99	1,572	16
17	Office Remodel - Walls			2001	2,000	51	15	133	82	189	17
18	Office Remodel - Walls			2001	2,000	51	15	133	82	189	18
19	Office Remodel - Flooring			2001	1,000		10	100	100	133	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Hickory Street Plac # 36764 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 217,953	$ 5,744		$ 8,803	$ 3,059	$ 50,720	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Beacon Street Place # 38729 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	4		1993	1960	$ 55,000	$ 1,410	25	$ 2,200	$ 790	$ 21,267	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodeling			1993	44,254	1,135	15	2,950	1,815	28,272	9
10	Sprinkler System			1993	7,800	200	15	520	320	4,983	10
11	Security System			1993	2,259		15	151	151	1,445	11
12	Carpet			1993	1,826		6			1,826	12
13	Flooring			1993	3,547		6			3,547	13
14	Cabinets			1993	2,456		15	164	164	1,571	14
15	Air Conditioner			1995	1,051	27	8	131	104	974	15
16	Landscaping			1996	2,418	143	10	242	99	1,572	16
17	Furnace			1996	1,030	26	15	69	43	423	17
18	Landscaping			1996	2,101	124	10	210	86	1,331	18
19	Carpet & Blinds			1997	3,074		5	461	461	3,074	19
20	Plumbing			1999	2,053	53	10	342	289	1,169	20
21	Office Remodel - Walls			2001	2,000	51	15	133	82	189	21
22	Office Remodel - Flooring			2001	1,000		10	100	100	133	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Beacon Street Place # 38729 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 131,869	$ 3,169		$ 7,673	$ 4,504	$ 71,776	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Autumn Leaves, Inc. d/b/a 44th Street Place # 38729 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	6		1998	1993	$ 198,000	$ 5,077	25	$ 7,920	$ 2,843	$ 34,980	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Asphalt Drive			1993	5,431	321	10	339	18	3,166	9
10	Carpet			1995	2,094		15	209	209	1,674	10
11	Landscaping			1996	2,418	143	6	242	99	1,572	11
12	Furnace			1999	1,285	33	6	86	53	293	12
13	Carpet			2000	1,550	271	7	310	39	672	13
14	Office Remodel - Walls			2001	2,000	51	15	133	82	189	14
15	Office Remodel - Flooring			2001	2,000		10	200	200	267	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Autumn Leaves, Inc. d/b/a 44th Street Place # 38729 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 214,778	$ 5,896		$ 9,439	$ 3,543	$ 42,813	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe Autumn Leaves, Inc. d/b/a Hickory Street Plac # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 20,056	$ 805	$ 1,678	$ 873	3-12 yrs	$ 15,322	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 20,056	$ 805	$ 1,678	$ 873		$ 15,322	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Program Transportation	1994 Dodge Van	1994	$ 12,701	$	$	$	4	$ 12,701	76
77	Transportation	1999 Grand Jeep	2002	23,373	3,060	4,675	1,615	4	4,675	77
78										78
79										79
80	TOTALS			$ 36,074	$ 3,060	$ 4,675	$ 1,615		$ 17,376	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 817,328	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 23,254	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 31,794	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,215	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 319,149	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquirec	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

Facility Name & ID Numbe Autumn Leaves, Inc. d/b/a Beacon Street Plac # 38729 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 27,369	$ 794	$ 2,085	$ 1,291	3-15 yrs	$ 20,697	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 27,369	$ 794	$ 2,085	$ 1,291		$ 20,697	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Program Transportation	1994 Dodge Caravan	1994	$ 18,235	$ 224	$	$ (224)	4	$ 18,235	76
77										77
78										78
79										79
80	TOTALS			$ 18,235	$ 224	$	$ (224)		$ 18,235	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquirec	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Numbe Autumn Leaves, Inc. d/b/a 44th Street Plac # 38737 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 27,504	$ 1,787	$ 2,116	$ 329	3-20 yrs	$ 17,720	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 27,504	$ 1,787	$ 2,116	$ 329		$ 17,720	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Program Transportation	1994 Dodge Van	1994	$ 17,483	$	$	$	4	$ 17,483	76
77	Transportation	1998 Lincoln	1997	47,007	1,775		(1,775)	4	47,007	77
78										78
79										79
80	TOTALS			$ 64,490	$ 1,775	$	$ (1,775)		$ 64,490	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquirec	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Hickory Street Place # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions				$			4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facilit

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training wa not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 20

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		5,508		5,508
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 5,508	$	$ 5,508
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,508			

C. CONTRACTUAL INCOME

In the box below record the amount of income you facility received training aides from other facilities

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	30
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	30

(a) Include wages paid during the classroom portion of training. Do not include fringe benefit
(b) Include wages paid during the clinical portion of training. Do not include fringe benefit
(c) For in-house training programs only. Do not include fringe benefit
(d) Allocate based on if the aide is from your facility or is being contracted to be trained i your facility. Drop-out costs can only be for costs incurred by your own aides

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8
(f) Attach a schedule of the facility names and addresse of those facilities for which you trained aides

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Hickory Street Place **#** 0036764 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 21,485	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	447,634		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,748		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 477,867	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	51,283		15
16	Equipment, at Historical Cost	186,093		16
17	Accumulated Depreciation (book methods)	(159,283)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 78,093	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 555,960	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 223,386	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	261,529		29
30	Accrued Salaries Payable	13,823		30
31	Accrued Taxes Payable (excluding real estate taxes)	135		31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,620		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,050		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 507,543	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 507,543	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 48,417	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 555,960	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Hickory Street Place # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 52,775	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 52,778	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	69,793	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(74,154)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (4,361)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 48,417	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Hickory Street Place # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 919,953	1
2	Discounts and Allowances for all Level	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 919,953	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Educatior	134,627	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement	12,763	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 147,390	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,067,343	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	227,090	31
32	Health Care	456,905	32
33	General Administratior	151,782	33
	B. Capital Expense		
34	Ownership	107,162	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	53,506	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 996,445	40
41	**Income before Income Taxes (line 30 minus line 40)****	70,898	41
42	**Income Taxes**	(1,105)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 69,793	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Hickory Street Plac # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	580	580	9,730	16.78	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	16,683	17,441	158,726	9.10	5
6	Nurse Aide Trainees	599	599	4,998	8.34	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,826	6,047	54,044	8.94	9
10	Activity Assistants	80	80	640	8.00	10
11	Social Service Worker	3,800	3,844	52,559	13.67	11
12	Dietician	4,724	5,078	54,405	10.71	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Worker	780	780	13,520	17.33	17
18	Housekeepers	5,580	5,893	54,493	9.25	18
19	Laundry					19
20	Administrator	1,040	1,040	15,024	14.45	20
21	Assistant Administrator	962	962	12,559	13.06	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	390	390	10,920	28.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	41,044	42,734	$ 441,618 *	$ 10.33	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	92	$ 3,230	1-3	35
36	Medical Director	Fee	8,185	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Fee	1,200	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan			10-3	41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant	149	6,703	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	Fee	1,120	12-3	45
46	Other(specify) Psychologist	Fee	2,250	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	241	$ 22,688		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number: Autumn Leaves, Inc. d/b/a Hickory Street Plac # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terri Dawson	Administrator	0	$ 15,024
Maria Neal	Admin Asst	0	9,247
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 24,271

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
May, Cocagne & King, P.C.	Accounting/Bookkeeping	$ 12,430
Paul Chiligiris	Legal	94
National City Bank	Banking Services	1,051
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 13,575

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 1,500
Unemployment Compensation Insurance	2,919
FICA Taxes	33,858
Employee Health Insurance	4,210
Employee Meals	5,937
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 48,424

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Miscellaneous Licenses	1,650
Dues & Subscriptions	593
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,243

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	519
Central Office Seminars (All in Illinois)	12
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 531

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Hickory Street Place # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Autumn Leaves, Inc. d/b/a Hickory Street Place # 0036764 Report Period Beginning: 1/1/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **No**

(2) Are there any dues to nursing home associations included on the cost repor **No**
If YES, give association name and amount

(3) Did the nursing home make political contributions or payments to a politic
action organization? **No** If YES, have these cost
been properly adjusted out of the cost report

(4) Does the bed capacity of the building differ from the number of beds licensed at t
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this perio **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. **0** Line

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports? **Yes** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangement **No**
If YES, give effective date of leas

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ov

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
of Public Aid during this cost report period. **53,506**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee? **Yes** If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed
the Department of Public Aid, in addition to the daily rate, been properly classifi
in the Ancillary Section of Schedule V **N/A**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac
a schedule which explains how all related costs were allocated to these functior

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **5,937** Has any meal income been offset agains
related costs? **No** Indicate the amount $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **No** If YES, please indicate the amount of income earned from such
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patient **100%**
d. Have vehicle usage logs been maintained **Yes**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjuste
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing suc
transportation during this reporting period $

(17) Has an audit been performed by an independent certified public accounting firm **No**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? If no, please explain

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report **N/A**
Attach invoices and a summary of services for all architect and appraisal fee

Autumn Leaves, Inc
d/b/a Hickory Street Place, Beacon Street Place, 44th Street Place
December 31, 2002

Documentation - Section V, Line 7, Column 3:

Waste Removal	1,094
Pest Control	1,488
Security	2,391
	4,973

Documentation - Section V, Line 15, Column 3:

Workshop	132,196
Podietry Care	36
Emergency Dental Care	981
	133,213

Documentation - Section V, Line 24, Column 8:

Seminars and meetings	531

All seminar expenses were for continuing education units (CEU's) for employees relating to patient care. All seminars were attended in Illinois.

Documentation - Section V, Line 30, Column 7:

Depreciation - Related Party	12,903
Straight-line adjustment	13,215
Central Office	3,962
	30,080

Reclassifications - Section V, Column 5:

	From Line #	To Line #	Amount
Employee Benefits (Staff Meals)	2	22	5,937

Page 7, ScheduleVII, C., Related Parties
Column 5, Compensation Received from Other Homes

David Jacobus

Drew Corp
Lovington, Illinois 29,128

Section XVII, Reconciliation of Income to Taxable Income:

Net Income (Loss) Per Books	69,798
Additions:	
Deductions:	
Change in accrued officer salaries	240
Taxable Income	70,038

Section XX, General Information, Question 12:

Salary costs are allocated based upon actual hours worked.